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Vermont Blueprint for Health
Expansion Design and Evaluation Committee

Meeting Minutes
October 12, 2010

Attendees: D. Barton, P. Biron, G. Bjornson, H. Blair, P. Cobb, K. Cooney, J. Gallimore, A. Garland, P. Harrington, M. Hartman, L. Hubbell, C. Jones, M. Phillips, L. McLaren, R. Messier, J. Peterson, L. Ruggles, N. Sarkar, J. Shaw, B. Hill, M. Scholten, R. Slusky, L. Dulsky Watkins

The meeting opened at 8:35 a.m.

1. *Update on Expansion*

- Pilots are currently operating in 3 communities. (Burlington, St. Johnsbury and Central Vermont)
- Pilot practices are receiving multi-insurance payments. Medicaid, MVP, BCBS and CIGNA are participating. Medicare will be making its decision soon as to whether or not they will participate. Our payment reform model differs from other payment reform initiatives.
- In response to Act 128, the program is expanding to all other hospital service areas in Vermont. We are required to have two fully implemented primary care practices in each hospital service area (HSA) by July 2011. The expansion process is moving forward aggressively.
- Practices must prepare themselves to be scored as a "Medical Home." There is ongoing planning around the Community Health Teams, (e.g., staffing, hiring, etc.) Several communities have already begun this work.
- Bennington and Mt. Ascutney are both going through their scoring process and are well into their development work and staffing process. We are hoping to have NCQA scoring for Mt. Ascutney before the end of the calendar year. Bennington is slated to start in November and Mt. Ascutney's tentative start date is January.
- Fletcher Allen currently has 5 practices ready to be scored.

General Hospital Service Area Grants

- Planning and readiness work is critical.
- Blueprint Grants, intended to support planning efforts, have been disbursed to all the HSA's.
- The dollar amounts of the grants vary. External stakeholders' should work directly with the grantees.
- General framework: One lead administrative entity will be designated for each HSA. Representatives for other services should be included in the planning process. There will be two working planning groups in each service area – a clinical workgroup and an IT workgroup. Hospitals should not be dominating the planning process. In each clinical practice there should be a "go to" person for IT issues.
- We will distribute the list of administrative leads ("Project Managers") for each HSA.
- The payers need specific information from Mt. Ascutney in order to move forward with expansion.
- We have chosen to have the NCQA scoring done by a third party, VCHIP of UVM. The scoring is designed to be an objective process. VCHIP is in the process of hiring additional staff to conduct the

NCQA scoring. Hospital Service Areas should notify VCHIP when they are ready to be scored to get them in the queue, although this does not mean they are "next". We have agreed to accept VCHIP's score to begin payments by the insurers pending final agreement by NCQA.

- Work is underway to connect practices to VITL

Pediatrics

- The initial focus of the Blueprint Program has been the adult population with chronic care issues. As a result of ACT 128 the program can now be expanded across all age groups.
- There is no need for a pediatric team as well as an adult team. We should be moving toward collaborative care based on community needs. While there is a need for pediatric expertise, a team focused exclusively on pediatrics is not necessary. The Community Health Teams are sized to population. (4 staff for every 20,000 general population of patients). The growth of a team is based on the population count.
- The CHIPRA Grant funds are to be used to help expand the Blueprint model to include pediatrics. We are currently in the planning process in regard to the use of the grant funds.
- The Blueprint is a guide – change agent. The Blueprint supplies the resources; however, the tactics and strategies are to be determined at the local level. The best strategies will be identified after each hospital service area has implemented their strategies at the local level and can assess "best practices".

2. *Community Health Team Payment Strategy – Shared vs. Proportional Costs:*

- Fee for service (FFS), which allows the insurers to compete and promotes volume, is still in place.
- Quality-driven payments will be disbursed to each practice. Funds distributed to the CHT's are intended to promote quality and care coordination.
- It is anticipated that the Multi-payer Claims data base will begin producing reports by the end of the year.
- We are promoting quality and will be measuring financial outcomes.
- The payment reforms do not include a risk/gain sharing component. The ultimate goal is to reduce insurance premiums for patients.
- We are investing in a foundation of advanced primary care medical homes. Home health agencies may benefit by improved efficiencies and enhanced coordination between various health care providers.
- Community Health Team payment strategy – shared vs. proportional (by insurer) costs. For the initial pilot projects we used the shared costs model. We will need to have a thoughtful discussion in regard to optimal methodology to determine the appropriate shared cost formula. This will be a key topic for the future and is a key component of payment reform.

3. *HIT Status*

- The State of Vermont is part of the national movement to build out HIT systems. There are clear national structures/guidelines for identifying and solving HIT problems.
- We are building a web based registry. The measures in this registry come directly from national guidelines.
- VITL is working on getting data feeds from practices to the central registry. This will help those practices that do not have EMR's.
- The system being built supports care and evaluates clinical measures.
- The key aspect of moving forward is to be able to work across organizations.

- We will set aside a dedicated meeting time to show the system to this group so that there will be a better understanding of what it really does.

4. *Other Business*
   - The Blueprint is hiring 7 practice facilitators. This will provide a stable team of coaches throughout Vermont. Live access to quality indicators will lessen the demand for VCHIP. This will allow VCHIP to move on a timelier basis in regard to scoring.
   - How is the expansion within existing pilots or to new hospital service areas being staged? Staging is being done at each HSA. We are required to have two practices in each hospital service area by next year.
   - The Payment Implementation Work Group has a telephone conference every month, to be expanded from 30 to 60 minutes as there is a great deal of work to do in the near future.
   - The payers need to be notified about which practices are ready or nearly ready to implement the program.
   - A hospital service area spreadsheet is being developed to track readiness and planning. Once fully developed, the spreadsheet will be shared with this group. The tracking sheet will be distributed on a regular basis.

With no further business, the meeting adjourned at 10:35 a.m.
Next meeting date:

Tuesday, December 14
8:30 – 10:30
DVHA
Large Conference Room
312 Hurricane Lane
Williston, VT